MEDICAL HISTORY FORM

Today's Date:_____

Title (Mr/Mrs/Miss/Ms/Dr/Other)_____

First Name _____

Surname _____

Contact Number _____

Email_____

Address _____

_____

_____

Postcode _____ State _____

Date of Birth _____

Gender_____

Occupation_____

Emergency Contact Name_____

Emergency Contact Number _____

Relationship_____

Name of person responsible for payment of accounts

_____

Private Health Fund / DVA Name (if applicable)

_____

Are you eligible for the Child Dental Benefits Scheme?

YES ☐ / NO ☐ If Yes please provide your:

Medicare Number: _____

Reference Number: _____

DENTAL HISTORY

What is your home oral hygiene routine?
(e.g. Electric or manual toothbrush, brush 2 times a day, flossing)

_____

_____

Who was your previous/usual general dentist?

_____

How long since your last **DENTAL VISIT**?

Less than 1 year ago	
Approx. 1 year ago	
More than 2 years	

When were your last **DENTAL X-RAYS** taken?

Less than 1 year ago	
More than 1 year ago	
Don't Remember	

ARE ANY TEETH SENSITIVE TO:

Hot or Cold?	
Sweet tastes?	
Biting or Chewing?	

HAVE YOU EXPERIENCED:

Clicking or popping of the jaw?	
Ear, face, jaw pain?	
Difficulty opening or closing your mouth?	
Difficulty chewing?	
Cold sores or blisters around your mouth?	
Loose teeth or a change in your bite?	
Food trapping between your teeth?	
Bleeding gums (when cleaning your teeth)?	

DO YOU:

Grind your teeth?	
Wear a dental night guard?	
Have aching jaws, especially in the mornings?	
Have a dry mouth?	
Suffer from occasional bad breath?	
Have a history of gum disease or tooth loss?	
Bite your cheeks, lips or tongue often?	

HAVE YOU EVER HAD:

Orthodontic treatment?	
Periodontal (gum) treatment?	
Your bite adjusted?	
Any teeth removed?	
Oral surgery?	
Sore gums?	
A serious injury to your mouth or head?	
If yes, please describe the injury:	

ARE YOU:

A current smoker/Vaper?	
If yes how many per day?	
A past smoker / Vaper?	
If so when did you quit?	
Pregnant?	
Breast Feeding?	
On any form of oral contraceptive?	

MEDICAL HISTORY FORM

MEDICAL HISTORY

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

Are you receiving any medical treatment at present?

YES ☐ / NO ☐

If yes, please provide details:_____

_____

Name of your medical practitioner/specialist:

_____

Surgery contact number:_____

Have you been hospitalised in the last 12 months?

YES ☐ / NO ☐

If yes, please list why: _____

_____

Are you taking any medication or supplements? (these can include herbal preparations, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants, etc.) We ask this so that we can take precautions to minimise risks and known negative interactions.

YES ☐ / NO ☐

If yes please list:

PLEASE INDICATE IF YOU HAVE HAD OR ARE BEING TREATED FOR ANY OF THE FOLLOWING:

Heart Condition / Heart Surgery	
High Blood Pressure	
Mitral Valve Prolapse	
Heart Valve / Pacemaker	
Stroke	
Rheumatic Fever	
Polymyalgia	
Lupus (SLE)	
Diet (special/restricted)	
Digestive Problems	
Gastroesophageal Reflux	
Gastric Ulcers	
Circulatory Problems	
Blood Pressure (high/low)	
Kidney / Renal Disease	
Liver Problems / Jaundice	
Diabetes	
Thyroid Disease	
Emphysema	
Chronic Cough	
Tuberculosis	
Lung Condition	
Bronchitis	

Asthma	
Hay fever	
Sinus Trouble	
Allergies (medicine, antibiotics, pain relievers, anaesthetic, antibiotics, contact allergies)	
Latex sensitivity	
Snoring / Sleep Apnoea	
Hepatitis	
Blood Borne Virus (AIDS/HIV, Hep B/C)	
Blood Transfusion	
Blood or Bleeding Disorder	
Anaemia	
Bruise or Bleed Easily	
Leukaemia	
Cancer	
Tumour History	
Radiation / Chemotherapy	
Neurological Disorder	
Epilepsy or Seizures	
Fainting or Dizzy Spells	
Anxiety	
Depression	
Psychiatric Condition	

Osteoporosis	
Arthritis / Rheumatism	
Bone Disorder or Disease	
Knee Reconstruction	
Prosthetic Implant	
Artificial Joints (hip, knee)	
Jaw / Neck Injury or Pain	
Steroid Therapy	
Transplant (organ, marrow)	
Infectious Disease (any)	
Other	

If you have answered yes or other, please provide details:

Any other relevant information:

MEDICAL HISTORY FORM

HOW DID YOU HEAR ABOUT US?

Signage / Walk by		Health Fund		Radio Advertising	
Doctor / Dentist Referral		Flyer / Leaflet		Social Media	
Internet / Google Search		School / Club/Sponsor		Word of Mouth / Referral	
Business Directory		Magazine or Print Media		Other	

CONSENT FOR TREATMENT

1. I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to contact my medical practitioner, who may release such information to you.
2. I consent to a dentist or designated team member to take x-rays, study models, photographs and other diagnostic aides as deemed appropriate by a dentist to make a thorough dental diagnosis.
3. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that if for any reason recovery of funds is required, and costs involved will be at my expense. I understand that if I cancel an appointment within 24 hours of my appointment, I may be liable for payment of a cancellation fee.
4. I agree to the Clinical Team using any photographs and xrays they take for educational purposes.

Patient Name:_____ Date: _____

Patient Signature: _____ Parent/Guardian:_____

WE RESPECT YOUR PRIVACY

Please read this Privacy Collection Statement to see how we use your personal information.

Maven Dental Group Pty Ltd ACN 131 333 492 and its related bodies corporate and our website www.mavendental.com.au collect, handle, use and protect your personal information in accordance with the *Privacy Act 1988* (Cth) and our Privacy Policy which can be viewed in full https://mavendental.com.au/privacy-policy. Alternatively, please ask our reception team for a copy of our Privacy Policy or contact us at the address below if you would like us to send you a copy.

We collect your personal information to provide you with products and services you have requested, improve our products and services, keep you informed of your upcoming appointments and notify you about our latest promotions and other offers relevant to you. We collect this information mainly through our communications with you, but we may do so also from other sources in the course of providing our services to you. You are not obliged to provide us with your personal information, however this may impact our ability to provide you with our products and services. We generally do not disclose information about you to any person and will only share your personal information where necessary to provide you with products and services, as required by law, or with your permission. Our Privacy Policy sets out how you can access and change your personal information or make a privacy complaint.

If you would like to:
- Inform us that you do not wish to receive promotional material,
- Request access to or the correction of information we hold about you,
- Make a complaint about our treatment of your privacy,

You can contact us on:
privacy@mavendental.com.au OR mail to:
The Privacy Officer, Maven Dental Group Pty Ltd,
PO Box 1146 Southport BC QLD 4215.

Name:_____ Signature: _____ Date: _____